

# **Self-stigma Narratives among Adolescents Taking Psychiatric Medication**

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## **Research Problem**

The extant literature describes stigma in two forms, public stigma and self-stigma. Although both types have negative impacts on people with mental illness, they produce different effects. Self-stigma corresponds to the internalized effects and can reduce self-esteem and willingness to engage in life opportunities (Corrigan & Kleinlein, 2005). Hinshaw (2005) states “there is an absence of research on the impact of stigma on children and adolescents who have experienced it themselves” (p. 723). Adolescent experience of self-stigma could be devastating to their future, as the literature describes adult experience of self-stigma as negatively impacting opportunities in employment, living situations and intimate relationships (Corrigan & Kleinlein, 2005).

Corrigan and Watson (2002) emphasize that few models represent self-stigma with adult mental illness. No models represent self-stigma in mental illness among adolescents. The adult self-stigma model suggests the first component is stereotype, wherein people with mental illness are exposed to negative beliefs about the self. The second component is prejudice; here the stigmatized individual agrees with the stereotype and emotionally internalizes it as a negative insult. In the third component, the person self-discriminates by the way he/she behaves in response to the prejudice (Corrigan & Watson, 2002). Discriminatory acts could include isolation or social withdrawal.

However, what we do not know is how the adolescent self-stigma process compares to adults, and there are plausible developmental reasons why youth might experience self-stigma differently. For instance, self-stigma processes may unfold differently for youth and it has the potential to become embedded as negative self-image earlier than an adult whose first experience with mental illness and stigma occur after formative identity experiences have been negotiated. A mental illness self-image created during the period of early identity formation is likely to affect young adulthood and adulthood. Thus, internalizing stigma could produce a drastic reduction in life

opportunities for adolescents (Hinshaw, 2007), and it could affect adolescents' identity formation experiences, seriously hampering their transition to adulthood (Zeltzer, 1985). Furthermore, adulthood provides integration of various aspects of identity and some kind of resolution among emergent conflicts (Erikson, 1968). In contrast, youth have little life experience with integration and identity resolutions and since self-stigma processes assume affects upon attitudes, beliefs, and self-esteem, it is likely that adult life experience may change, buffer, or neutralize reactions to stereotypes and prejudice.

This exploratory study aims to sketch a model that can be useful to future research on the self-stigma process for adolescents. Ultimately, the awareness raised by qualitatively analyzing first person accounts is invaluable because developing interventions that include the effects of self-stigma are more likely to be efficacious and long-lasting (Boyd Ritsher et al., 2003).

### **Research Question**

- 1) What is the self-stigma process among adolescents with mental illness?

### **Methodology**

The sample was drawn from a secondary data set gathered by the principal investigator of an NIMH K08 award to develop the methods and conduct research on subjective medication experience of psychotropic treatment. The participants were between the ages of 12-17 (N=27). The study recruited participants through convenient sampling. The average age of the adolescents was approximately 14 years (M=14.4, SD=1.79). The sample included 67% females (n=18) and 33% males (n=9), 56% Caucasians (n=15) and 37% African Americans (n=10). A total of 96% (n=26) of the adolescents were prescribed between 1 and 3 psychiatric medications. Over 74% (n=20) of the participants were diagnosed as having a mood disorder, and 56% (n=15) were diagnosed as having ADHD; the N of diagnoses is greater than 100% due to the presence of comorbidities.

The qualitative instrument employed in this study was the TeenSEMI, which was adapted from the AdultSEMI. The AdultSEMI was designed to obtain narrative data about medication treatment from those diagnosed with schizophrenia (Jenkins, 1997). The TeenSEMI was produced by eliminating or modifying questions for adults (e.g., questions that pertained to work, marriage, and recovery) and developing age-relevant questions (e.g., questions that pertained to school, peer, and family interactions).

The data analytic strategy, structural analysis, utilized a narrative method (Riessman, 2008) to examine the most common temporal and plot components of the self-stigmatization process. Structural analysis pays particular attention to how the narrator organizes content. In the first step of structural analysis, I read and reread each interview. Next, I organized each respondent's TeenSEMI answers by constructing a

narrative that contained some or all of the following six elements: 1) abstract-summary or point of the story; 2) orientation-to time, place, characters and situation; 3) complicating action-the event sequence or plot, usually with a crisis or turning point; 4) evaluation-where the narrator steps back from the action to comment on meaning and communicate emotions; 5) resolution-the outcome of the plot; 6) coda-ending the story and bringing back to the present (Riessman, 2008, p. 84).

This step also reduced the interview material by including only quotations relevant to firsthand descriptions of stigma related experiences. Moreover, applying the six elements to each transcribed interview necessarily organized the narrative as having a past, present, and future, allowing me to identify the common temporal and plot components of the self-stigmatization process. Finally, the determination of whether or not a respondent experienced the effects of self-stigma was assessed by systematically coding for one of three indicators of stigma effects: shame, secrecy, and limiting interaction (Link et al, 1989).

## Results

The analytic strategy led to a self-stigma model that had three potential plot components: stereotype, differentiate, and protect (See Appendix). These plot components roughly correspond to a temporal sense of living with a mental illness and daily taking a prescribed medication. One feels past stereotypes, negotiates sense of differentness because of illness, and protects their sense of self and reputation when interacting with others. It is worth noting that each participant did not self-report stigma; it was inductively and deductively derived from comparing their firsthand accounts within and among respondents (Kranke et al., 2010).

First, adolescents responded to stereotypes about their illness or use of medications by pondering over the meaning of the stereotype and how it applied to them. For example, respondents said that others often refer to individuals with bipolar disorder as “crazy,” or indicate that medications are for people who are “psycho.” In many cases, “crazy” and “psycho” people were described as acting bizarre or not fitting in because of their behavior or looks, consistent with stereotypes. Adolescents’ statements about people with mental illness were often similar to ideas described by family, peer, or the popular media.

In the second plot component, differentiate, adolescents acknowledge differentness: “I do not feel normal because of the medication.” These adolescents compared their self-reliance and ability to function with peers who did not take medication because they were focused on fitting in with their social environment. The medications were needed to return a sense of control and balance to these adolescents’ lives. As some described, the medications “returned them to a normal playing field.”

However, some were concerned about peer perceptions, thus, did not want their differentness to be associated with medication use. Ultimately, adolescents managed their illness with their developing sense of autonomy. This transformation initiated changes in behavior and sense of self-reliance, leading the adolescent to alter specific interests, coping mechanisms, and knowledge of self. Some accepted the fact that medication is needed to control aspects of their illness, while others did not want to give up that sense of autonomy, and ultimately rejected any positive impact of the medication. They were reluctant to accept the new self-image, as it induced shame, especially when they perceived themselves to be different from peers, “mental” or “cuckoo.”

Third, adolescents protected their vulnerable altered sense of self and their reputation by censoring their need for psychiatric medication when socially interacting because they did not want to be ostracized or humiliated for being different. Youth are negotiating their self-image, and interference by negative peer perceptions could tarnish it. Adolescents protected this developing self-image by covering up evidence or details that linked them to a mental illness when interacting with peers and adults. Some would fabricate the use of their medications, while others hid their medications in locations that could not be easily found. They wanted to be perceived as normal as possible. A loss of social capital could lead to exclusion from peers, and ultimately limit rightful social and educational opportunities in the future.

## **Implications for Social Work/Practice**

This exploratory study of adolescents provided a somewhat different, yet similar process of self-stigma when compared with adults. Clearly, the components are significantly impacted by developmental issues appropriate to the stigmatized individual. In particular, the adolescent self-stigma process incorporates developmental issues of autonomy (Brockman, 2003), peer perceptions (Karp, 2006) and integration of various aspects of identity (Erikson, 1968). These developmental tasks contribute to the variation in the model amongst adolescents as youth are consumed with a developing self-image. There is concern over the long term trajectory of youth who self-stigmatize because the process has implications for future opportunities of youth, particularly with respect to self-esteem and self-efficacy. Understanding how self-stigma unfolds while becoming an adult is critical for developing effective interventions, and ultimately preserving the ability to capitalize on career opportunities and meaningful relationships.

Although this study provides exploratory data about youth and self-stigma, future work is needed to validate this model. A quantitative research design that could correlate findings to developmental differences and follow respondents longitudinal would be the appropriate design for validating the proposed model.

Were this proposed self-stigma model to be validated, the findings suggest the need to provide adolescents with psychosocial interventions that would prevent them from internalizing shame for taking psychiatric medication. Solomon (2004) illustrates how peer support and role models that promote self-images “help to enhance the number of individuals that a person with a psychiatric disability can turn to for support and assistance, offer a sense of belonging and positive feedback of a person’s own self worth” (p. 394). Peer support research demonstrates positive outcomes in enhancing quality of life (Davidson, et al., 1999). Interventions that include peer mentors and self-help/stigma reduction groups are ones like Active Minds and NAMI, as well as school-based therapy groups, supported education and empowerment models. Interactions with others who also experience mental illness stigma could help these youth integrate a positive future orientation.

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*Appendix 1. Self-stigma Example*

